Prescription Reimbursement Request Form

Use this form to request reimbursement for covered medications not processed electronically at your pharmacy. Complete one form per claim.

Member Information

Group ID (See ID Card)	Member ID (See ID Card)
Last Name	First Name
Address	City, State Zip
Date of Birth	Best Contact Phone Number:

Reason for Request:

- ○ I did not use my Prescription Drug ID card
- ○ I used a non-participating pharmacy *(please explain)*
- ○ I received a compounded prescription
- ○ I purchased medication outside of the United States

Country_____ Currency used _____

- ○ My primary coverage is with another insurance carrier *(coordination of benefits claim; please include copy of other insurance card)*
  - ○ I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - ○ I am submitting a copay receipt
- ○ I was waiting for a drug approval
- ○ I was retroactively enrolled with the plan
- ○ My pharmacy billed the wrong plan
- ○ Other *(please explain)*_____

Acknowledgement:

The medication(s) for which I am seeking reimbursement were received for use by the member above. The medication(s) was not prescribed as the result of an on-the-job injury. I acknowledge that reimbursement will be paid directly to the member and assignment of these benefits to a pharmacy or any other party is void if I am eligible for prescription drug benefits.

Signature (signature of parent or guardian if member is under age 18):

_____

******Submit with this form a copy of the receipt from the claim in question.***

Acknowledgement: Submission

Send a copy of this form and the receipt to: **memberservices@epiphanyrx.com**

Or mail to:

EpiphanyRx, LLC

Attn: Claims Dept

278 Franklin Ste 242

Brentwood, TN 37027